

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospital and Provider Operations

4 (Amendment)

5 907 KAR 3:005. Physicians' services.

6 RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184,

7 440.50, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d - 8

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1)

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
10 Services, Department for Medicaid Services, has responsibility to administer the Medi-  
11 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
12 comply with any requirement that may be imposed or opportunity presented by federal  
13 law for the provision of medical assistance to Kentucky's indigent citizenry. This admin-  
14 istrative regulation establishes the provisions relating to physicians' services for which  
15 payment shall be made by the Medicaid Program on behalf of both the categorically  
16 needy and the medically needy.

17 Section 1. Definitions. (1) "Biologicals" means the definition of biologicals pursuant to  
18 42 USC 1395x(t)(1).

19 (2) "Common practice" means a contractual partnership in which a physician assis-  
20 tant administers health care services under the employment and supervision of a physi-  
21 cian.

1 (3)~~(2)~~ "Comprehensive choices" means a benefit plan for an individual who:

2 (a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

3 (b) Receives services through either:

4 1. A nursing facility in accordance with 907 KAR 1:022;

5 2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

6 3. The Home and Community Based Waiver Program in accordance with 907 KAR  
7 1:160; or

8 4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

9 (c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

10 (4)~~(3)~~ "CPT code" means a code used for reporting procedures and services per-  
11 formed by physicians and published annually by the American Medical Association in  
12 Current Procedural Terminology.

13 (5)~~(4)~~ "Department" means the Department for Medicaid Services or its designee.

14 (6)~~(5)~~ "Direct physician contact" means that the billing physician is physically pre-  
15 sent with and evaluates, examines, treats, or diagnoses the recipient.

16 (7) "Drug" means the definition of drugs pursuant to 42 USC 1395x(t)(1).

17 (8)~~(6)~~ "Emergency care" means:

18 (a) Covered inpatient and outpatient services furnished by a qualified provider that  
19 are needed to evaluate or stabilize an emergency medical condition that is found to ex-  
20 ist using the prudent layperson standard; or

21 (b) Emergency ambulance transport.

22 (9)~~(7)~~ "EPSDT" means early and periodic screening, diagnosis, and treatment.

23 (10)~~(8)~~ "Family choices" means a benefit plan for an individual who:

1 (a) Is covered pursuant to:

2 1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u - 1;

3 2. 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E  
4 of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

5 3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

6 4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

7 5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

8 6. Has a designated package code of 2, 3, 4, or 5.

9 ~~(11)~~~~(9)~~ "Global period" means occurring during the period of time in which related  
10 preoperative, intraoperative, and postoperative services and follow-up care for a surgi-  
11 cal procedure are customarily provided.

12 ~~(12)~~~~(40)~~ "Global choices" means the department's default benefit plan, consisting of  
13 individuals designated with a package code of A, B, C, D, or E and who are included in  
14 one (1) of the following populations:

15 (a) Caretaker relatives who:

16 1. Receive Kentucky Transitional Assistance Program (K-TAP) benefits ~~[K-TAP]~~ and  
17 are deprived due to death, incapacity, or absence;

18 2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or ab-  
19 sence; or

20 3. Do not receive K-TAP benefits and are deprived due to unemployment;

21 (b) Individuals aged sixty-five (65) and over who receive supplemental security in-  
22 come (SSI) benefits ~~[SSI]~~ and:

23 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR

- 1 1:022; or
- 2 2. Receive state supplementation program (SSP) benefits [SSP] and do not meet
- 3 nursing facility patient status criteria in accordance with 907 KAR 1:022;
- 4 (c) Blind individuals who receive SSI benefits and:
- 5 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
- 6 1:022; or
- 7 2. SSP benefits, and do not meet nursing facility patient status criteria in accordance
- 8 with 907 KAR 1:022;
- 9 (d) Disabled individuals who receive SSI benefits and:
- 10 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
- 11 1:022, including children; or
- 12 2. SSP benefits, and do not meet nursing facility patient status criteria in accordance
- 13 with 907 KAR 1:022;
- 14 (e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are
- 15 eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient
- 16 status criteria in accordance with 907 KAR 1:022;
- 17 (f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through"
- 18 Medicaid benefits, and do not meet nursing facility patient status in accordance with 907
- 19 KAR 1:022;
- 20 (g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass
- 21 through" Medicaid benefits, and do not meet nursing facility patient status in accordance
- 22 with 907 KAR 1:022; or
- 23 (h) Pregnant women.

1        ~~(13)~~~~(41)~~ "Graduate medical education program" or "GME Program" means one (1)  
2 of the following:

3        (a) A residency program approved by:

4            1. The Accreditation Council for Graduate Medical Education of the American Medi-  
5 cal Association;

6            2. The Committee on Hospitals of the Bureau of Professional Education of the Ameri-  
7 can Osteopathic Association;

8            3. The Commission on Dental Accreditation of the American Dental Association; or

9            4. The Council on Podiatric Medicine Education of the American Podiatric Medical  
10 Association; or

11        (b) An approved medical residency program as defined in 42 C.F.R. 413.75(b).

12        ~~(14)~~~~(42)~~ "Incidental" means that a medical procedure is performed at the same time  
13 as a primary procedure and:

14            (a) Requires little additional resources; or

15            (b) Is clinically integral to the performance of the primary procedure.

16        ~~(15)~~~~(43)~~ "Integral" means that a medical procedure represents a component of a  
17 more complex procedure performed at the same time.

18        ~~(16)~~~~(44)~~ "KenPAC" means the Kentucky Patient Access and Care System.

19        ~~(17)~~~~(45)~~ "KenPAC PCP" means a Medicaid provider who is enrolled as a primary  
20 care provider in the Kentucky Patient Access and Care System.

21        ~~(18)~~~~(46)~~ "Locum tenens" means a substitute physician:

22            (a) Who temporarily assumes responsibility for the professional practice of a physi-  
23 cian participating in the Kentucky Medicaid Program; and

1 (b) Whose services are paid under the participating physician's provider number.

2 (19)~~(17)~~ "Medically necessary" or "medical necessity" means that a covered benefit  
3 is determined to be needed in accordance with 907 KAR 3:130.

4 (20)~~(18)~~ "Medical resident" means one (1) of the following:

5 (a) An individual who participates in an approved graduate medical education (GME)  
6 program in medicine or osteopathy; or

7 (b) A physician who is not in an approved GME program, but who is authorized to  
8 practice only in a hospital, including:

9 1. An individual with a:

10 a. Temporary license;

11 b. Resident training license; or

12 c. Restricted license; or

13 2. An unlicensed graduate of a foreign medical school.

14 (21)~~(19)~~ "Mutually exclusive" means that two (2) procedures:

15 (a) Are not reasonably performed in conjunction with one another during the same  
16 patient encounter on the same date of service;

17 (b) Represent two (2) methods of performing the same procedure;

18 (c) Represent medically impossible or improbable use of CPT codes; or

19 (d) Are described in Current Procedural Terminology as inappropriate coding of pro-  
20 cedure combinations.

21 (22)~~(20)~~ "Optimum choices" means a benefit plan for an individual who:

22 (a) Meets the intermediate care facility for individuals with mental retardation or a de-  
23 velopmental disability patient status criteria established in 907 KAR 1:022;

1 (b) Receives services through either:

2 1. An intermediate care facility for individuals with mental retardation or a develop-  
3 mental disability in accordance with 907 KAR 1:022; or

4 2. The Supports for Community Living Waiver Program in accordance with 907 KAR  
5 1:145; and

6 (c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.

7 (23)~~[(21)]~~ "Other licensed medical professional" means a health care provider other  
8 than a physician, physician assistant, advanced registered nurse practitioner, certified  
9 registered nurse anesthetist, nurse midwife, or registered nurse who has been approved  
10 to practice a medical specialty by the appropriate licensure board.

11 (24)~~[(22)]~~ "Physician assistant" is defined in KRS 311.840(3).

12 (25)~~[(23)]~~ "Screening" means the evaluation of a recipient by a physician to deter-  
13 mine the presence of a disease or medical condition and if further evaluation, diagnostic  
14 testing or treatment is needed.

15 (26) "Special handling, storage, shipping, dosing or administration requirements"  
16 means one of more of the following requirements as described in the dosing and ad-  
17 ministration section of a medication's package insert:

18 (a) Refrigeration of the medication;

19 (b) Protection from light until time of use;

20 (c) Overnight delivery;

21 (d) Avoidance of shaking or freezing; or

22 (e) Other protective measures not required for most orally-administered medications.

23 (27)~~[(24)]~~ "Supervising physician" is defined in KRS 311.840(4).

1 ~~(28)~~~~(25)~~ "Supervision" is defined in KRS 311.840(6).

2 ~~(29)~~~~(26)~~ "Timely filing" means receipt of a claim by Medicaid:

3 (a) Within twelve (12) months of the date the service was provided;

4 (b) Within twelve (12) months of the date retroactive eligibility was established; or

5 (c) Within six (6) months of the Medicare adjudication date if the service was billed to  
6 Medicare.

7 ~~(30)~~~~(27)~~ "Unlisted procedure or service" means a procedure for which there is not a  
8 specific CPT code and which is billed using a CPT code designated for reporting  
9 unlisted procedures or services.

10 Section 2. Conditions of Participation. (1) A participating physician shall be licensed  
11 as a physician in the state in which the medical practice is located.

12 (2) A participating physician shall comply with the terms and conditions established in  
13 the following administrative regulations:

14 (a) 907 KAR 1:005, Nonduplication of payments;

15 (b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding over-  
16 payments, administrative appeal process, and sanctions; and

17 (c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid  
18 participation.

19 (3) A participating physician shall comply with the requirements regarding the confi-  
20 dentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d - 8 and 45 C.F.R.  
21 Parts 160 and 164.

22 (4) A participating physician shall have the freedom to choose whether to accept an  
23 eligible Medicaid recipient and shall notify the recipient of that decision prior to the de-

1 livery of service. If the provider accepts the recipient, the provider:

2 (a) Shall bill Medicaid rather than the recipient for a covered service;

3 (b) May bill the recipient for a service not covered by Medicaid if the physician in-  
4 formed the recipient of noncoverage prior to providing the service; and

5 (c) Shall not bill the recipient for a service that is denied by the department on the  
6 basis of:

7 1. The service being incidental, integral, or mutually exclusive to a covered service or  
8 within the global period for a covered service;

9 2. Incorrect billing procedures, including incorrect bundling of services;

10 3. Failure to obtain prior authorization for the service; or

11 4. Failure to meet timely filing requirements.

12 Section 3. Covered Services. (1) To be covered by the department, a service shall  
13 be:

14 (a) Medically necessary;

15 (b) [~~Effective August 1, 2006,~~] Clinically appropriate pursuant to the criteria estab-  
16 lished in 907 KAR 3:130;

17 (c) Except as provided in subsection (2) of this section, furnished to a recipient  
18 through direct physician contact; and

19 (d) Eligible for reimbursement as a physician service.

20 (2) Direct physician contact between the billing physician and recipient shall not be  
21 required for:

22 (a) A service provided by a medical resident if provided under the direction of a pro-  
23 gram participating teaching physician in accordance with 42 C.F.R. 415.174 and

1 415.184;

2 (b) A service provided by a locum tenens physician who provides direct physician  
3 contact;

4 (c) A radiology service, imaging service, pathology service, ultrasound study, echo-  
5 graphic study, electrocardiogram, electromyogram, electroencephalogram, vascular  
6 study, or other service that is usually and customarily performed without direct physician  
7 contact;

8 (d) The telephone analysis of emergency medical systems or a cardiac pacemaker if  
9 provided under physician direction;

10 (e) A preauthorized sleep disorder service if provided in a physician operated and  
11 supervised sleep disorder diagnostic center;

12 (f) A telehealth consultation provided by a consulting medical specialist in accordance  
13 with 907 KAR 3:170; or

14 (g) A service provided by a physician assistant in accordance with Section 7 of this  
15 administrative regulation.

16 (3) A service provided by an individual who meets the definition of other licensed  
17 medical professional shall be covered if:

18 (a) The individual is employed by the supervising physician;

19 (b) The individual is licensed in the state of practice; and

20 (c) The supervising physician has direct physician contact with the recipient.

21 Section 4. Service Limitations. (1) A covered service provided to a recipient placed in  
22 "lock-in" status in accordance with 907 KAR 1:677 shall be limited to a service provided  
23 by the lock-in provider unless:

- 1 (a) The service represents emergency care; or
- 2 (b) The recipient has been referred by the "lock-in" provider.
- 3 (2) An EPSDT screening service shall be covered in accordance with 907 KAR
- 4 1:034, Sections 3 through 5.
- 5 (3) A laboratory procedure performed in a physician's office shall be limited to a pro-
- 6 cedure for which the physician has been certified in accordance with 42 C.F.R. Part
- 7 493.
- 8 (4) Except for the following, a drug administered in the physician's office shall not be
- 9 covered as a separate reimbursable service through the physician program:
- 10 (a) Rho (D) immune globulin injection;
- 11 (b) An injectable antineoplastic drug;
- 12 (c) Medroxyprogesterone acetate for contraceptive use, 150 mg;
- 13 (d) Penicillin G benzathine injection;
- 14 (e) Ceftriaxone sodium injection;
- 15 (f) Intravenous immune globulin injection;
- 16 (g) Sodium hyaluronate or hylan G-F for intra-articular injection;
- 17 (h) An intrauterine contraceptive device; [øf]
- 18 (i) An implantable contraceptive device;
- 19 (j) Long acting injectable risperidone; or
- 20 (k) An injectable, infused or inhaled drug or biological that is:
- 21 a. Not typically self-administered;
- 22 b. Not excluded as a noncovered immunization or vaccine; and
- 23 c. Requires special handling, storage, shipping, dosing or administration.

1 (5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F, shall  
2 be covered within the scope and limitations of the federal regulations.

3 (6) Coverage for a service designated as a psychiatry service CPT code and pro-  
4 vided by a physician other than a board certified or board eligible psychiatrist shall be  
5 limited to four (4) services, per physician, per recipient, per twelve (12) months.

6 (7)(a) Coverage for an evaluation and management service shall be limited to one (1)  
7 per physician, per recipient, per date of service.

8 (b) Coverage for an evaluation and management service with a corresponding CPT  
9 code of 99214 or 99215 shall be limited to two (2) per recipient per year, per diagnosis,  
10 per physician, except as established in paragraph (c) of this subsection.

11 (c) An evaluation and management service with a corresponding CPT of 99214 or  
12 99215 exceeding the limit established in paragraph (b) of this subsection shall be cov-  
13 ered if prior authorized by the department.

14 (8) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2)  
15 per nine (9) month period per recipient unless the diagnosis code justifies the medical  
16 necessity of an additional procedure.

17 (9)(a) An anesthesia service shall be covered if administered by an anesthesiologist  
18 who remains in attendance throughout the procedure.

19 (b) Except for an anesthesia service provided by an oral surgeon, an anesthesia ser-  
20 vice, including conscious sedation, provided by a physician performing the surgery shall  
21 not be covered.

22 (10) The following services shall not be covered:

23 (a) An acupuncture service;

- 1 (b) Allergy immunotherapy for a recipient age twenty-one (21) years or older;
- 2 (c) An autopsy;
- 3 (d) A cast or splint application in excess of the limits established in 907 KAR 3:010,
- 4 Section 4(5) and (6);
- 5 (e) Except for therapeutic bandage lenses, contact lenses;
- 6 (f) A hysterectomy performed for the purpose of sterilization;
- 7 (g) Lasik surgery;
- 8 (h) Paternity testing;
- 9 (i) A procedure performed for cosmetic purposes only;
- 10 (j) A procedure performed to promote or improve fertility;
- 11 (k) Radial keratotomy;
- 12 (l) A thermogram;
- 13 (m) An experimental service which is not in accordance with current standards of
- 14 medical practice; or
- 15 (n) A service which does not meet the requirements established in Section 3(1) of
- 16 this administrative regulation.

17 Section 5. Prior Authorization Requirements and KenPAC Referral Requirements. (1)

18 The following procedures shall require prior authorization by the department:

- 19 (a) Magnetic resonance imaging (MRI);
- 20 (b) Magnetic resonance angiogram (MRA);
- 21 (c) Magnetic resonance spectroscopy;
- 22 (d) Positron emission tomography (PET);
- 23 (e) Cineradiography/videoradiography;

- 1 (f) Xeroradiography;
- 2 (g) Ultrasound subsequent to second obstetric ultrasound;
- 3 (h) Myocardial imaging;
- 4 (i) Cardiac blood pool imaging;
- 5 (j) Radiopharmaceutical procedures;
- 6 (k) Gastric restrictive surgery or gastric bypass surgery;
- 7 (l) A procedure that is commonly performed for cosmetic purposes;
- 8 (m) A surgical procedure that requires completion of a federal consent form; or
- 9 (n) An unlisted procedure or service.

10 (2)(a) Prior authorization by the department shall not be a guarantee of recipient eli-  
11 gibility.

12 (b) Eligibility verification shall be the responsibility of the provider.

13 (3) The prior authorization requirements established in subsection (1) of this section  
14 shall not apply to:

15 (a) An emergency service; or

16 (b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.

17 (4) A referring physician, a physician who wishes to provide a given service, or an  
18 advanced registered nurse practitioner may request prior authorization from the de-  
19 partment.

20 (5) A referring physician, a physician who wishes to provide a given service, or an  
21 advanced registered nurse practitioner shall request prior authorization by mailing or  
22 faxing:

23 (a) A written request to the department with sufficient information to demonstrate that

1 the service meets the requirements established in Section 3(1) of this administrative  
2 regulation; and

3 (b) If applicable, any required federal consent forms.

4 (6) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a  
5 referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC  
6 Program.

7 Section 6. Therapy Limits. (1) Speech therapy shall be limited to:

8 (a) Ten (10) visits per twelve (12) months for a recipient of the Global Choices benefit  
9 plan;

10 (b) Thirty (30) visits per twelve (12) months for a recipient of the:

11 1. Comprehensive Choices benefit plan; or

12 2. Optimum Choices benefit plan.

13 (2) Physical therapy shall be limited to:

14 (a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices  
15 benefit plan;

16 (b) Thirty (30) visits per twelve (12) months for a recipient of the:

17 1. Comprehensive Choices benefit plan; or

18 2. Optimum Choices benefit plan.

19 (3) Occupational therapy shall be limited to:

20 (a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices  
21 benefit plan;

22 (b) Thirty (30) visits per twelve (12) months for a recipient of the:

23 1. Comprehensive Choices benefit plan; or

1        2. Optimum Choices benefit plan.

2        (4) The therapy limits established in subsection (1) through (3) of this section shall be  
3 over-ridden if the department determines that additional visits beyond the limit are medi-  
4 cally necessary.

5        (5)(a) To request an override:

6            1. The provider shall telephone or fax the request to the department; and

7            2. The department shall review the request in accordance with the provisions of 907  
8 KAR 3:130 and notify the provider of its decision.

9        (b) An appeal of a denial regarding a requested override shall be in accordance with  
10 907 KAR 1:563.

11        (6) The limits established in subsections (1), (2), and (3) of this section shall not apply  
12 to a recipient under twenty-one (21) years of age. Except for recipients under age  
13 twenty-one (21), prior authorization is required for each visit that exceeds the limit es-  
14 tablished in subsection (1) through (3) of this section.

15        Section 7. Physician Assistant Services. (1) With the exception of a service limitation  
16 specified in subsections (2) or (3) of this section, a service provided by a physician as-  
17 sistant in common practice with a Medicaid-enrolled physician shall be covered if:

18            (a) The service meets the requirements established in Section 3(1) of this administra-  
19 tive regulation;

20            (b) The service is within the legal scope of certification of the physician assistant;

21            (c) The service is billed under the physician's individual provider number with the  
22 physician assistant's number included; and

23            (d) The physician assistant complies with:

1 1. KRS 311.840 to 311.862; and

2 2. Sections 2(2) and (3) of this administrative regulation.

3 (2) A same service performed by a physician assistant and a physician on the same  
4 day within a common practice shall be considered as one (1) covered service.

5 (3) The following physician assistant services shall not be covered:

6 (a) A physician noncovered service specified in Section 4(10) of this administrative  
7 regulation;

8 (b) An anesthesia service;

9 (c) An obstetrical delivery service; or

10 (d) A service provided in assistance of surgery.

11 Section 8. Appeal Rights. (1) An appeal of a department decision regarding a Medi-  
12 caid recipient based upon an application of this administrative regulation shall be in ac-  
13 cordance with 907 KAR 1:563.

14 (2) An appeal of a department decision regarding Medicaid eligibility of an individual  
15 shall be in accordance with 907 KAR 1:560.

16 (3) An appeal of a department decision regarding a Medicaid provider based upon an  
17 application of this administrative regulation shall be in accordance with 907 KAR 1:671.

907 KAR 3:005

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Glenn Jennings, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mark D. Birdwhistell, Secretary  
Cabinet for Health and Family Services

907 KAR 3:005

A public hearing on this administrative regulation shall, if requested, be held on August 21, 2007, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by August 14, 2007, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2007. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

**CONTACT PERSON:** Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:005

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the participation requirements for physicians and the coverage criteria for services provided by physicians to Medicaid recipients.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws requiring provision of medical services to Kentucky's indigent citizenry.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation fulfills requirements implemented in KRS 194A.050(1) related to the execution of policies to establish and direct health programs mandated by federal law.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides the necessary criteria and denotes the limitations for the provision of medically necessary physician services to Medicaid recipients.
  
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: This amendment establishes coverage of administration of a long acting injectable risperidone or an injectable, infused or inhaled drug or biological that is not typically self-administered, not excluded as a noncovered immunization or vaccine and requires special handling, storage, shipping, dosing or information; and increases evaluation and management service coverage from one (1) per recipient per year to two (2) per recipient per year with additional coverage contingent upon department prior authorization.
  - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure or enhance recipient access to physician care via the department's coverage structure and to promote recipient health, safety and welfare by reimbursing for administration of drugs or biologicals requiring special handling or similar.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendment establishes reimbursement to promote recipient access to physician care and to promote recipient health, safety and welfare within the extent and scope authorized by state and federal law by.
  - (d) How the amendment will assist in the effective administration of the statutes: The amendment establishes reimbursement to promote recipient access to physician care and to promote recipient health, safety and welfare within the

extent and scope authorized by state and federal law by.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Reimbursement policies pertaining to covered Medicaid services impacts all physicians enrolled in the Kentucky Medicaid program (approximately 15,000).
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
  - (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Rather than restrict coverage, the amendments favor providers, enhancing coverage. The amendment extends coverage to administration of certain drugs and biologicals which require special handling or similar and expands evaluation and management service per recipient per year coverage from one (1) to two (2) with additional allowed if prior authorized by the department.
  - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is anticipated, the amendments enhance coverage rather than restrict.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The amendments enhance coverage rather than restrict coverage. The amendments extend coverage to administration of certain drugs and biologicals which require special handling or similar and expands evaluation and management service per recipient per year coverage from one (1) to two (2) with additional allowed if prior authorized by the department.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
  - (a) Initially: The fiscal impact is contingent upon utilization which cannot be accurately predicted at this time; therefore, the impact is indeterminable. The Department for Medicaid Services (DMS) anticipates the enhanced coverage may cost money; however, the measures are necessary to enhance recipient access to physician care. Additionally, covering administration of drugs and biologicals which require special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.
  - (b) On a continuing basis: The fiscal impact is contingent upon utilization which cannot be accurately predicted at this time; therefore, the impact is indeterminable. DMS anticipates the enhanced coverage may cost money; however, the measures are necessary to enhance recipient access to physician care. Additionally, covering administration of drugs and biologicals which require special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 3:005

Contact Person: Stuart Owen or Stephanie  
Brammer-Barnes (564-6204)

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes  X  No \_\_\_\_\_  
If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect all physicians enrolled in the Medicaid program.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 CFR 447 Subpart B.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
  - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.
  - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.
  - (c) How much will it cost to administer this program for the first year? DMS anticipates the enhanced coverage may cost money; however, the measures are necessary to enhance recipient access to physician care. Additionally, covering administration of drugs and biologicals which require special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.
  - (d) How much will it cost to administer this program for subsequent years? DMS anticipates the enhanced coverage may cost money; however, the measures are necessary to enhance recipient access to physician care. Additionally, covering administration of drugs and biologicals which require special handling may re-

duce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): \_\_\_\_\_

Expenditures (+/-): \_\_\_\_\_

Other Explanation: No additional expenditures are necessary to implement this amendment.